WALTER REED ARMY MEDICAL CENTER
CENTER FOR REFRACTIVE SURGERY

Instructions for Completing Commanders Endorsement Form

1. Please carefully complete all the information in the form and ensure that it is legible, so please print.
2. Please be specific and complete concerning your MOS. For example it is not sufficient to report “armor” you are required to use your numeric designation.
3. Please be complete and specific about your assigned unit.
4. Since we will use email as the first line of communication please make sure that the email address you provide is one that you regularly use.
5. If at any time you change your contact information please be sure to let us know the new information.
6. If you do not have surgery within 6 months of this Endorsement being signed you will be asked to provide an updated version before your surgery.
7. Please fax this form to The Center for Refractive Surgery (CRS) with your Referral and Deployment Statement (if required) at 202-782-4653. We will not keep any copies of the documentation you send us so remember to keep the original and bring it with you to your first appointment at CRS.
8. If you have any questions or need other assistance please do not hesitate to call CRS at 202-782-0202 / 0204 (DSN 662-0202 / 0204) at any time between 0800 and 1530 EST Monday through Friday except for holidays.

(Office Symbol)_____ (Date)_____

MEMORANDUM TO OIC, Center for Refractive Surgery Center, WRAMC

SUBJECT: Commander's Endorsement of Refractive Eye Surgery

1. I hereby give my endorsement/permission for the below listed active duty soldier to be evaluated and considered for enrollment in the warfighter refractive eye surgery program (WRESP) and for their treatment if eligible.

Name: _____
Last First MI
SSN: _____ ETS DATE: _____
RANK: _____ SERVICE: _____
DUTY TITLE: _____ MOS: _____
ASSIGNED UNIT: _____
CONTACT ADDRESS: _____
CONTACT PHONE: (DAY)_____(EVES)_____
E-MAIL ADDRESS: _____

2. I realize that after the surgery, the soldier will have the following profile for a minimum of 30 days (100%), but possibly up to 90 days in a small number of patients (<10%).
   a. No parachuting
   b. No diving
   c. No night operations
   d. No duty requiring strenuous activities to include APFT

3. Must keep all follow-up appointments with refractive eye surgery clinic to avoid potential complications.

4. I further realize that the soldier must remain CONUS for at least 30 days following the surgery.

5. The soldier will be on unit convalescent leave for up to 96 hours following surgery.

6. The soldier has a minimum of 18 months active duty service commitment remaining.

7. National Guard and Reserves are not eligible for treatment under the WRESP

_____ _____ _____
Applicants Signature Commander's signature Date

_____
Commander's Name and Rank

_____
Unit

_____
Commander's Telephone number and e-mail